Tool and Guideline for Substance Abuse Treatment

Facility_____ CIS#_____ Date_____
Residential___ Outpatient___

Eligibility

1. Is HIV status documented by a lab test, physician's letter or a current Ryan White certified referral?
   Yes There is a positive lab test for HIV antibodies, a signed physician's letter on letterhead stating the client is HIV positive or a certified referral dated within 6 months prior to the service delivery date.
   No There is no lab test, no signed physician's letter on letterhead stating the client is HIV positive or there is no certified referral dated within 6 months prior to the service delivery date.

2. Is there proof of financial eligibility or a current Ryan White certified referral?
   Yes There is proof of financial eligibility (one of the following: 2-3 mos. paystubs, case action letter, W-2 form, statement from employer, notarized letter of support or notarized letter of declaration from the client) or there is a current (within 6 mos. prior to service delivery date) certified referral.
   No None of the documents listed above are present.

3. Is there proof of Miami-Dade County residency?
   Yes There is at least one of the following: Florida driver's license or ID, rental lease or deed, utility bill in client's name, declaration of domicile, or a current (within 6 mos. prior to service date) certified referral.
   No None of the documents listed above are present.

4. Is there a signed, dated consent to exchange and release information in the SDIS?
   Yes There is a signed and dated consent to exchange and release information in the SDIS.
   No There is no consent form.
   No Consent is not signed.
   No Consent is not dated.

5. Is socio-demographic data documented (age, race/ethnicity, gender, primary or preferred language)?
   Yes Client's age, race/ethnicity, gender and primary or preferred language are documented in the record.
   No Client's age or race/ethnicity, gender, primary or preferred language is/are missing.

6. Is there signed, dated documentation (Composite Consent Form) that:
   a. grievance procedures have been explained?
      a. Yes There is signed, dated documentation of explanation of grievance procedures.
      a. No There is no documentation grievance procedures were explained.
      a. No Documentation is unsigned.
      a. No Documentation is undated.

   b. client's rights and responsibilities have been explained?
      b. Yes There is signed, dated documentation client's rights and responsibilities explained
      b. No There is no documentation client's rights and responsibilities explained.
      b. No Documentation is unsigned.
      b. No Documentation is undated.

   c. client's right to confidentiality explained?
      c. Yes There is signed, dated documentation client's right to confidentiality explained.
      c. No There is no documentation client's right to confidentiality explained.
      c. No Documentation is unsigned.
      c. No Documentation is undated.

   d. client's obligation to maintain confidentiality of others in treatment explained?
      d. Yes There is documentation client's obligation to maintain confidentiality of others in treatment explained.
      d. No There is no documentation client's obligation to maintain confidentiality of others in treatment explained.
      d. No Documentation is unsigned.
      d. No Documentation is undated.

7. Is there a signed, dated informed consent for treatment?
   Yes There is a signed, dated consent for substance abuse treatment.
   No There is no consent for substance abuse treatment or consent.
   No Documentation is unsigned.
   No Documentation is undated.
   NA Client seen in emergency and transferred to another facility.

8. Is there a signed, dated consent for urinalysis in the record?
   Yes There is a signed , dated consent for urinalysis.
   No There is no consent for urinalysis.
   No Documentation is unsigned.
   No Documentation is undated.

HIV/AIDS Issues

9. Were client risk related behaviors assessed?
   Yes There is an assessment of client's HIV risk related behaviors.
   No There is no documented assessment of client's HIV risk behaviors.

10. Was education provided on decreasing risk behaviors, e.g., safer sex and not sharing needles?
    Yes Education was provided toward decreasing risk behaviors.
    No There is no documentation of education to decrease risk behaviors.

11. Was adherence to HIV treatment and medications discussed?
    Yes There is documentation of discussion of adherence to treatment and medications.
    No There is no discussion of adherence to treatment and medications documented.

Assessment/Treatment

12. Is there documentation of a medical history completed by:
    Residential: MD, ARNP, PA, RN, LPN within 24 hours of admission?
    Yes There is a medical history documented by appropriate within 24 hours of admission.
    Outpatient: client or legal guardian upon admission.
    Yes There is a medical history documented by the client or legal guardian upon admission.
    Residential, and Outpatient:
    No There is no medical history documented.
    No Documentation time exceeds appropriate time frame.

13. Is there an addiction history that includes age of onset, choice of drug, patterns and consequences of use, and prior treatment completed prior to or within:
    Residential: 5 working days of admission?
    YES Addiction history is complete, includes required elements and dated within 5 working days of admission.
    Outpatient: 4 sessions or 30 days of admission, whichever comes first.
    YES Addiction history is complete, includes required elements and Dated within 4 sessions or 30 days of admission, whichever comes first.
    Residential, and Outpatient:
    No The addiction history is incomplete.
    No Date exceeds appropriate time frame.
    NA Client left program prior to given time frames for completing addiction history.

14. Is there an American Society of Addiction Medicine (ASAM) assessment performed within:
    Residential: 5 working days of admission?
        YES ASAM assessment is performed within 5 working days of admission.
    Outpatient: 4 sessions or 30 days of admission, whichever comes first?
        YES ASAM assessment is performed within 4 sessions or 30 days of admission, whichever comes first.
        NO ASAM assessment not performed.
        NO Date exceeds appropriate time frame.
        NA Client left program prior to time frames for completing assessment.

15. Is there an Interpretive Summary documented after assessments complete:
    Residential: 5 working days of admission?
        YES Interpretive Summary is completed within 5 working days of admission.
    Outpatient: 4 sessions or 30 days of admission whichever comes first?
        YES Interpretive Summary is completed within 4 sessions or 30 days of admission, whichever comes first.
        NO Interpretive Summary is not completed.
        NO Date exceeds appropriate time frame.
        NA Client leaves program prior to time frames for completing Interpretive Summary.

16. Is there an initial treatment plan developed at the time of admission?
        Yes Initial treatment plan was developed at the time of admission.
        No Initial treatment plan missing.
        No Initial treatment plan is present, but was not developed at the time of admission.

17. Is the initial treatment plan signed and dated by the clinician and the client?
        Yes The initial treatment plan is signed and dated by the clinician and client.
        No The initial treatment plan is missing one or more signatures.
        No The initial treatment plan is missing one or more dates.

18. **Residential only:** Is there a physical exam documented by MD, PA or ARNP within 10 days of admission?
        Yes There is a physical exam completed within 10 days of admission.
        No There is no physical exam.
        No Exam is not completed within 10 days.
        NA Client left program prior to given time frame for action.
        NA Client is enrolled in outpatient treatment.

19. **Residential only:** Were the following performed at the time of the physical exam or within 30 days of admission?
    a. Serological test for STDs?
        a. Yes Serological test for current and past Syphilis performed within appropriate time frame.
        a. No Serological test for current Syphilis not performed.
        a. No Serological test for past Syphilis not performed.
        a. No One or both tests not performed within appropriate time frame.
        a. NA Client left program prior to given time frame for Syphilis testing.
    b. Mantoux TB test?
        b. Yes Mantoux TB test performed within appropriate time frame.
        b. No Mantoux TB test not performed.
        b. No Mantoux TB not performed within appropriate time frame.
        b. NA Client left program prior to given time frame for Mantoux TB test.

20. Is there screening for critical psychological problems (serious depression, thoughts of suicide, hallucinations, dementia) performed within:
    Residential: 5 working days of admission?
    Outpatient: 4 sessions or 30 days of admission, whichever comes first?
        Yes Screening for critical psychological problems is performed and dated within appropriate time frame.
    Residential and Outpatient:
        No Screening for critical psychological problems not performed.
        No Screening for critical psychological problems not performed within appropriate time frame.
        NA Client withdrew from treatment prior to time frame for screening of psychological problems.

21. Is there an individual treatment plan developed for the client within:
    Residential: 7 working days of admission?
    Outpatient: within 4 sessions or 30 days whichever comes first?
    Residential and Outpatient:
        Yes Individual treatment plan present and completed within appropriate time frame.
        No There is no individual treatment plan or plan is incomplete.
        NA Client withdrew from treatment prior to timeframe for completing individual treatment plan.

22. Is the individual treatment plan signed and dated by the therapist and the client?
        Yes The treatment plan is signed and dated by both the therapist and client.
        No The treatment plan lacks one or more signatures.
        No The treatment plan lacks one or more dates.
        NA There is no treatment plan.

23. Is the treatment plan reviewed every thirty days, signed and dated by client and therapist?

    Yes Treatment plan is reviewed, signed and dated every thirty days by client and therapist.
    No Treatment plan is not reviewed every thirty days.
    No Treatment plan is not signed by client or therapist.
    NO Treatment plan is not dated by client or therapist.
    NA There is no treatment plan.

24. Are there progress notes dated and signed by clinical staff documenting client progress or lack of progress toward meeting the objectives of the treatment plan, at least weekly?

    Yes There are progress notes signed and dated by clinical staff documenting the client's progress or lack of progress toward treatment plan goals, at least weekly.
    No Progress notes are not entered on a weekly basis.
    No Progress notes do not relate to treatment plan objectives.
    No Progress note is not dated or not signed.
    NA Client left program prior to first weekly note.

25. Does the record contain a medication administration record (residential) or copies of prescriptions (outpatient)?

    Yes Medication administration record (residential) or copies of prescription(s) (outpatient) are in record.
    No There is no medication administration record (residential) or copies of prescriptions (outpatient) in the record.
    NA Client is not on medications or, if outpatient, medications prescribed by PCP.

26. Is there documentation of referral for ancillary services that includes results?

    Yes There is a record of referral for ancillary services that includes results.
    No Client was referred for ancillary services but there is no record or no results.
    NA Client was not referred for ancillary services.

27. Does the discharge plan include a summary of client's involvement in treatment, reason for the discharge, plans for needed services after discharge including after care?

    Yes There is a discharge plan that includes all of the required components.
    No There is no discharge plan.
    No One or more required component(s) is/are missing.
    NA Client has not been discharged.

28. Is there a discharge ASAM assessment?
    Yes There is an ASAM assessment completed at discharge.
    No There is no ASAM assessment or assessment is incomplete.
    NA The client is not discharged from the program.

29. **Residential only:** Is there a referral to an Outpatient Program at discharge or a note that continued Outpatient Care not needed at discharge?
    Yes There is a referral to or a note denying necessity for Outpatient treatment.
    No There is no reference at discharge concerning continuing need for treatment in an Outpatient setting.
    NA Client is not discharged or client is transferred from program.

30. Is there a signed, dated transfer summary completed for clients transferring either to another component of same program or to another provider?
    Same Program: immediately
    Yes Client was transferred within provider and summary is completed immediately.
    Another Provider: within 5 working days
    Yes Client was transferred to another provider and summary is completed within 5 working days.
    No Client was transferred and summary is not completed.
    Same Program/Another Provider
    No Client was transferred and summary is not completed.
    No Client was transferred and summary dated after appropriate time frame.
    No Client was transferred and summary not signed.
    NA Client was not transferred.

31. Is there a transfer ASAM assessment?
    Yes there a transfer ASAM assessment completed at time of transfer.
    No There is no ASAM assessment done at time of transfer.
    NA Client was not transferred.